Department of Human Services
Bureau of Human Service Licensing
# LICENSING INSPECTION SUMMARY - PUBLIC

February 6, 2023

[redacted]
WOODS SERVICES, INC.
[redacted]

RE: BEECHWOOD CENTER 2
589 BEECHWOOD CIRCLE
LANGHORNE, PA, 19047
LICENSE/COC#: 12964

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/02/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

## Facility Information

**Name**: *BEECHWOOD CENTER 2* **Licen e #**: *12964* **Licen e Expiration**: *11/01/2023*

**Address**: *589 BEECHWOOD CIRCLE, LANGHORNE, PA 19047*

**County**: *BUCKS* **Region**: *SOUTHEAST*

## Administrator

**Name**: [redacted] **Phone**: [redacted] **Email**: [redacted]

## Legal Entity

**Name**: *WOODS SERVICES, INC.*

**Address**: [redacted]

**Phone**: [redacted] **Email**: [redacted]

## Certificate(s) of Occupancy

**Type**: *Other* **Date**: *04/22/1998* **I ued By**: *L&I*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *10* **Waking Staff**: *8*

## Inspection Information

**Type**: *Full* **Notice**: *Unannounced* **BHA Docket #**:

**Reason**: *Renewal* **Exit Conference Date**: *11/02/2022*

## Inspection Dates and Department Representative

*11/02/2022 On Site* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *8* **Residents Served**: *8*

### Secured Dementia Care Unit

**In Home**: *No* **Area**: **Capacity**: **Residents Served**:

### Hospice

**Current Residents**: *0*

### Number of Residents Who:

**Receive Supplemental Security Income**: *5* **Are 60 Years of Age or Older**: *0*

**Diagnosed with Mental Illness**: *0* **Diagnosed with Intellectual Disability**: *0*

**Have Mobility Need**: *2* **Have Physical Disability**: *0*

# Inspections / Reviews

### 11/02/2022 - Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/24/2022*

### 12/01/2022 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *12/16/2022*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/06/2022*

## Inspections / Reviews *(continued)*

**12/07/2022 - POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *12/16/2022*

**Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/16/2022*

**02/06/2023 - Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *12/16/2022*

**Reviewer:** [redacted] **Follow-Up Type:** *Not Required*

## 65d - Initial Direct Care Training

**1. Requirements**

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

**Description of Violation**

*The home does not have a certificate of completing and passing the Department -approved direct care training course on file for direct care staff person A hired on [redacted]/2019 and for staff person B hired on [redacted]/2022.*

**Plan of Correction** ***Accept (CM - 12/01/2022)***

*• An audit of DHS certificates was completed on the home by the Director of Licensing on 11/4/22 and both certificates were located.*
*• To ensure future completion of the DHS training course for all new employees, the class has been included in the new hire orientation provided by Woods Training Department starting on 11/14/22.*

**Licensee's Proposed Overall Completion Date:** *11/30/2022*

***Implemented ([redacted] - 02/06/2023)***

## 88a - Surfaces

**2. Requirements**

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

*On 11/02/2022 around 10:00 AM, the bathroom floor right outside of the shower in the bathroom between resident room[redacted] and [redacted] was covered with water, causing a slipping hazard.*

**Plan of Correction** ***Accept [redacted] - 12/07/2022)***

*• A squeegee was purchased by the Director of Community Residences and provided to the staff of the home to guide the water into the drain following showers.*
*• The housekeeper will use the squeegee to push the pooling water into the drain daily following the morning showers in the bathroom until the floor can be assessed and repaired.*
*• A request was submitted by the Director of Community Residences to maintenance on 11/27/22 to have the drain evaluated for repair.*
*• The drain was repaired on 11/28/22*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented ([redacted] - 02/06/2023)***

## 103i - Outdated Food

**3. Requirements**

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

## 103i - Outdated Food *(continued)*

**Description of Violation**

*There was an unlabeled, undated zip-lock bag of sliced cheese and out dated zip-lock bag of deli meats in the kitchen refrigerator. There was an un abeled, undated bag of dinner rolls and an almost finished bag of bread.*

**Plan of Correction** ***Accept ([redacted] - 12/07/2022)***

*• Unlabeled and outdated food was discarded by Director of Licensing on 11/2/22.*

*• Staff in the home will be trained on the safe management of food and expectations by the Assistant Director 12/7/22.*

*• Food items will be monitored by the Personal Care Home Administrator and checked thoroughly during the monthly environmental check of the home starting 12/1/22.*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented [redacted] - 02/06/2023)***

## 107a - Emergency Preparedness

**4. Requirements**

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

**Description of Violation**

*The home does not have a copy of the emergency preparedness plan for the local municipality.*

**Plan of Correction** ***Accept ([redacted] - 12/07/2022)***

*• The local municipality emergency preparedness plan was placed in the home by the Director of Licensing on 11/2/22.*

*• The plan will be included in the monthly environmental audit completed by the Personal Care Home Administrator starting 12/1/22.*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented [redacted] 02/06/2023)***

## 132b - Safety Inspection/Fire Drill

**5. Requirements**

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

**Description of Violation**

*The home did not have a fire drill conducted by a fire safety expert in 2021. The suspension of this regulation was lifted with instruction to have this completed by 12/31/2021.*

**Plan of Correction** ***Accept [redacted] - 12/07/2022)***

*• An observed fire drill and fire safety inspection was completed on 6/8/21. Requests to the inspector were unsuccessful to show supporting documentation of completion.*

*• An observed fire drill and fire safety inspection was completed on 6/3/22 and documentation was provided.*

*• The Director of Licensing will be responsible to schedule observed fire drills and fire safety inspections annually to*

## 132b - Safety Inspection/Fire Drill (continued)

*meet the regulatory standard 2600.132.b. A standing annual reminder is set for 5/1/22 for the Director to contact the fire safety expert and schedule the drills.*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented [redacted] - 02/06/2023)***

## 141b1 - Annual Medical Evaluation

**6. Requirements**

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

**Description of Violation**

*Resident #1's initial medical evaluation was completed on [redacted]/2020 and the resident's annual medical evaluation was completed on [redacted]/2021.*

**Plan of Correction** ***Accept ([redacted] - 12/07/2022)***

*• The late Annual Medical Evaluation was discovered by the Nursing Department following the [redacted]/21 visit.*
*• A tracking system was implemented [redacted]21 for the Medical Scheduler to ensure that the Medical Evaluations are completed annually.*
*The annual dates are maintained on a spreadsheet and referenced by the Medical Scheduler weekly to ensure that the timeline is met.*
*This tracking system does not have an end date to its use.*
*• Resident #1's most recent medical evaluation was completed on [redacted]22.*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented [redacted] - 02/06/2023)***

## 184a - Resident's Meds Labeled

**7. Requirements**

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

**Description of Violation**

*The prescription order for resident #1's [redacted] was changed from every 6 hours as needed to every 4 hours as needed on 09/03/2022. On 11/02/2022, there was a blister pack of [redacted] with the original label of every 6 hours as needed without the direction change sticker on.*

**Plan of Correction** ***Accept [redacted] - 12/07/2022)***

*• Resident #1's label was updated to reflect the current prescription by the Nursing Lead on 11/2/22.*
*• Nursing staff responsible for updating medication labels upon prescription changes will be re-trained in the procedure by the AVP of Nursing Services on 11/30/22.*
*• Monthly cart checks starting 12/5/22 completed by the nursing staff and monitored by nursing managers have been incorporated into the new electronic MAR system to assist with identifying and preventing future errors.*

**Licensee's Proposed Overall Completion Date:** *12/05/2022*

## 184a - Resident's Meds Labeled *(continued)*

***Implemented [redacted] - 02/06/2023)***

## 185a - Implement Storage Procedures

**8. Requirements**

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

**Description of Violation**

*Resident #2 is prescribed accuchecks 5 times a day. The numbers on the resident's glucometer and the log do not match:*

- *10/27 04:35 PM [redacted] not on the log*
- *10/26 12:07 PM [redacted] vs [redacted]*
- *10/26 07:24 PM [redacted] not on the log*
- *10/25 12:08 PM [redacted] vs [redacted]*
- *10/21 07:33 AM [redacted] vs [redacted]*
- *10/19 08:32 AM [redacted] vs [redacted]*

*Repeat Violation: 08/27/2021 et al.*

**Plan of Correction** ***Accept [redacted] 12/07/2022)***

- *Nursing staff responsible for scanning and documenting the glucometer readings will be re-trained by the AVP of Nursing Services on 11/30/22.*
- *The Nursing Manager will complete weekly checks/reviews of the documentation and glucometer readings starting 12/5/22 for at least three months to ensure that the nursing staff are accurately implementing the glucometer procedures.*
- *After 3 months of weekly monitoring (Week of 3/5/22) the AVP of Nursing Services will review the reports submitted at the end of each month and determine if monitoring can taper to monthly.*

**Licensee's Proposed Overall Completion Date:** *12/05/2022*

***Implemented ([redacted] 02/06/2023)***

## 185b - Medication Procedures

**9. Requirements**

2600.
185.b. At a minimum, the procedures must include:

**Description of Violation**

*Resident #1 is prescribed [redacted] every 4 hours as needed. According to the [redacted] sign-out log, one pill was wasted on [redacted]/2022 at [redacted] PM but there was no staff/witness signature present. No pill was signed out on [redacted]/2022 but there is staff initials present on the resident's October medication administration record (MAR).*

**Plan of Correction** ***Accept ([redacted] - 12/07/2022)***

- *Nursing staff responsible for medication administration [redacted] will be re-trained in the medication procedures by the AVP of Nursing Services on 11/30/22.*

## 185b - Medication Procedures (continued)

*• The Nursing Manager will complete weekly checks [redacted] (starting 12/5/22 and going at least 3 months) to ensure that the nursing staff are following the procedures.*
*• After 3 months of weekly monitoring starting 12/5/22 and going at least 2 months, the AVP of Nursing Services will review the reports (submitted at the end of each month) and determine if monitoring can taper to monthly.*

**Licensee's Proposed Overall Completion Date:** *12/05/2022*

***Implemented [redacted] - 02/06/2023)***

## 187b - Date/Time of Medication Admin.

**10. Requirements**

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

**Description of Violation**

*Resident #1 is prescribed [redacted] 4 times a day as needed. The resident's October MAR does not include the initials of the staff person who administered it on [redacted] /2022 at [redacted] and [redacted] /2022 at [redacted]*
*The same resident is prescribed [redacted] every 4 hours as needed. The resident's October MAR does not include the initials of the staff person who administered it on at [redacted] PM on [redacted] /2022 and [redacted] /2022.*

*Repeat Violation: 12/02/2021 et al.*

**Plan of Correction** ***Accept [redacted] - 12/07/2022)***

*• Nursing staff responsible for medication administration and signing the MAR will be re-trained in the medication procedures by the AVP of Nursing Services on 11/30/22.*
*• The Nursing Manager will complete weekly checks (starting on 12/5/22 and lasting for at least 3 months) of the MAR to ensure that the nursing staff are signing at the time of administration.*
*• After 3 months of weekly monitoring (3/5/22), the AVP of Nursing Services will review the reports (turned in at the end of each month) and determine if monitoring can taper to monthly.*

**Licensee's Proposed Overall Completion Date:** *12/05/2022*

***Implemented [redacted] - 02/06/2023)***

## 201 - Positive Interventions

**11. Requirements**

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

**Description of Violation**

*The home's designated smoking area is located at the back porch. On 11/02/2022 around 12:05 PM, two residents were observed smoking outside on the lamp of the left side of the building. According to staff members, they do not always smoke in the home's designated smoking area. The home has not implemented positive interventions to modify or eliminate this behavior.*

## 201 - Positive Interventions *(continued)*

**Plan of Correction** ***Accept ( 12/07/2022)***

*• The Director of Community Homes will post no smoking signs in the areas of concern as an added reminder to the individuals we serve by 12/31/22.*
*• The Director of Community Homes will meet with the staff on 12/1/22 to review the smoking policy and offer support regarding ways to implement positive interventions. For those indicated as violating the smoking area, staff will verbally recognize when the proper procedures are followed by those we support.*
*Should staff observe someone smoking outside of the smoking area they should remind the individual of the smoking area and kindly ask them to adhere. This interaction will further be logged on a report by the observer in the EHR and included as discussion during the monthly program review conference by the Personal Care Home Administrator.*
*• The Director of Community Homes will hold a house meeting on 12/1/22 to discuss and review the smoking policy with those living in the home. The policy will be included in the monthly house meeting by the Personal Care Home Administrator following any concerns reported by staff regarding the designated smoking areas.*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented - 02/06/2023)***

## 221c - Post Activity Calendar

**12. Requirements**

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

**Description of Violation**

*There was no activity calendar posted in a public and conspicuous place in the home.*

**Plan of Correction** ***Accept 12/07/2022)***

*• The weekly activity calendar was posted by the Assistant Director on 11/2/22.*
*• The Personal Care Home Administrator will be responsible for posting the activity schedule monthly.*
*• The activity schedule will be included in the monthly environmental review completed by the Personal Care Home Administrator starting 12/1/22.*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented - 02/06/2023)***

## 224a - Preadmission Screen Form

**13. Requirements**

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

**Description of Violation**

*Resident #2 was originally admitted to a different building on the same campus in and then was transferred to current building on about 1 and 1/2 month stay; however, the home did not complete a new screening form for the resident.*

## 224a - Preadmission Screen Form *(continued)*

**Plan of Correction** ***Accept [redacted] 12/07/2022)***

*• To ensure that all documentation is completed when transfers occur between two licensed homes, an internal transfer checklist tool was created for the Care Coordination team to use. The internal transfer checklist has been in place since August 2022. It is utilized by the Care Coordination team each time a participant transfers from one residence to another. The Care Coordination team is comprised of a Director of Care Coordination and Four Care Coordinators.*

*• The Director of Care Coordination met with the Care Coordinators on 11/8/22 to train them on the use of the tool to ensure thorough completion of documentation.*

**Licensee's Proposed Overall Completion Date:** *12/01/2022*

***Implemented [redacted] - 02/06/2023)***

## 225c - Additional Assessment

**14. Requirements**

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

**Description of Violation**

*Resident #3's most recent assessment was completed on [redacted] 2021.*

**Plan of Correction** ***Accept [redacted] - 12/07/2022)***

*•Resident 3's assessment was updated on [redacted] 22 by Resident #3's current Care Coordinator. To ensure that all documentation is completed when transfers occur between two licensed homes, an internal transfer checklist tool was created and implemented August 2022 for the Care Coordination team to use. It is utilized by the Care Coordination team each time a participant transfers from one residence to another. The Care Coordination team is comprised of a Director of Care Coordination and Four Care Coordinators.*

*• The Director of Care Coordination met with the Care Coordinators on 11/8/22 to train them on the use of the tool to ensure thorough completion of documentation.*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented [redacted] 02/06/2023)***

## 227g Support Plan Signatures

**15. Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

**Description of Violation**

*The support plan dated [redacted] /2021 for resident #3 and the one dated [redacted] /2021 for resident #4 were not signed by the assessor.*

**Plan of Correction** ***Accept (CM - 12/07/2022)***

*• On 11/8/22 the Director of Care Coordination held a training with the Care Coordination team to review the proper completion of the Residential Assessment and Support Plan. The applicable 2600 regulations were reviewed in detail and the importance of obtaining applicable signatures was stressed. Scenarios and reviews of RASP's were*

## *227g -Support Plan Signatures (continued)*

*utilized as teaching tools and performance improvement measures to help the team improve their understanding of the information that should be included.*
*Step1 Care completes the RASP with input from the residential staff and treatment team.*
*Step 2 The RASP is reviewed at the Rehabilitative Support Plan (RSP) meeting with the participant and treatment team.*
*Step 3 Signatures are obtained on the RASP at the time of the meeting.*
*This process has been in place since 2019. The training conducted on 11/8/22 was a review of this process.*
*Starting in January 2023 quarterly audits will be completed by the Director of Care Coordination and the Care Coordinators of a sampling of resident records for thoroughness. The audit goal is to reach a minimum of 20% of the records annually and will be under the responsibility of the Director of Care Coordination.*

**Licensee's Proposed Overall Completion Date:** *12/06/2022*

***Implemented [redacted] 02/06/2023)***